HICKORY
North Carolina
Life. Well Crafted.

☐ **New Enrollment** (Waiting periods apply. www.hickorync.gov)
☐ **Open Enrollment** (Waiting periods apply. www.hickorync.gov)

Change:
☐ **Coverage** (Complete Parts A,B,C,D,F,G,H,I)
☐ **Health plan** (Complete Parts A,B,D,H,I)
☐ **Name** (Complete Parts A,I)
☐ **Life Insurance Beneficiary** (Complete Parts A,E,F,I)
☐ **Optional Life Insurance** (Complete Parts A,F,I)

Benefits Enrollment Form

PART A Legal Marital Status: ☐ Married ☐ Not Married | Sex: ☐ Male ☐ Female | Date of Birth: | Employment Date:

Name: LAST | FIRST | MI | FORMER LAST NAME (IF CHANGED) | SOCIAL SECURITY NUMBER

Address: STREET OR P.O. BOX | CITY | STATE | ZIP CODE | TELEPHONE | EMAIL ADDRESS

PART B **MEDICAL INSURANCE COVERAGE** ☐ PPO ☐ HSA ☐ I Decline Coverage ☐ No Change

Please choose one of the following: ☐ Employee only ☐ Employee & Child ☐ Employee & Children

PART C **DENTAL COVERAGE** ☐ Employee only ☐ Spouse ☐ Child ☐ Children ☐ Family ☐ I Decline Coverage ☐ No Change

VISION COVERAGE ☐ Employee only ☐ Spouse ☐ Children ☐ Family ☐ I Decline Coverage ☐ No Change

PART D Dependents-Complete in Full-List any Additional Dependents on the back of this form.

ADD	DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
☐	☐								☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life
☐	☐								☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life
☐	☐								☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life
☐	☐								☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life
☐	☐								☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

PART E **BENEFICIARY DESIGNATION** - BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE* (City Provided)

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ADDRESS	BENEFICIARY DESIGNATION PRIMARY-CLASS 1	CONTINGENT -CLASS 2
						☐ Primary	☐ Contingent
						☐ Primary	☐ Contingent
						☐ Primary	☐ Contingent

*IMPORTANT: Please list your beneficiaries for your Basic Life and AD&D insurance. (City provided) List additional beneficiaries on back of this form. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)

PART F **OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE** ☐ I Elect coverage ☐ I Decline coverage ☐ No Change

Employee Paid - Submit within 30 days of hire or medical statement required | Amount: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

List additional beneficiaries on back of this form. Beneficiaries will be the same as for Basic Life (Part E), unless you list different beneficiaries on back.

PART G **DEPENDENT OPTIONAL LIFE INSURANCE** - List Dependent information in Part D

☐ I Elect Coverage (Additional form required) ☐ I Decline Coverage ☐ No Change

OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE

☐ I Elect coverage (Additional form required) ☐ I Decline Coverage ☐ No Change

PART H **MEDICAL INSURANCE PLAN CHANGE** Date of Change:

☐ Open Enrollment ☐ From: ☐ PPO ☐ HSA with contribution ☐ HSA without contribution

To: ☐ PPO ☐ HSA with contribution ☐ HSA without contribution

DEPENDENT COVERAGE CHANGES Date of change:

Reason for change:
☐ Marriage ☐ Newly eligible for coverage ☐ Dependent died
☐ Spouse's Coverage terminated ☐ Child reached age limit ☐ Divorce
☐ Other, specify _____ ☐ No longer a student ☐ Birth/Adoption

PART I I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. Medical and dental insurance deduction is paid on a pre-tax basis unless a waiver form is submitted.

Employee Signature | Date

**** FOR OFFICE USE ONLY ****

Health Effective Date	**Dental** Effective Date	**Vision** Effective Date	**Basic Life/AD&D** Effective Date	**Optional Life /AD&D** Effective Date